

03018

## CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSIE MAY ASHLEY</u>				4. DATE OF DEATH Month Day Year <u>MARCH 13 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 8, 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE WASHINGTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY WARNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-14-8583</u>		17. INFORMANT Address <u>William R Ashley Millington Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>some years</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetic melitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-25</u> 19 <u>57</u> to <u>3-13</u> 19 <u>57</u> that I last saw the deceased alive on <u>3-12</u> 19 <u>57</u> , and that death occurred at <u>3 A</u> M; from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D.				ADDRESS (Street, city or town, state) <u>Millington Md</u>		DATE SIGNED <u>3-13-57</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MILLINGTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hollows</u>				ADDRESS <u>Millington Md.</u>		24a. REC'D BY REGISTRAR <u>Clay Mulford</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

100-15

BUREAU V. S.

MAR 19 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03007 CERTIFICATE OF DEATH

Reg. Dist. No.

03010  
202

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LESLIE</b> Middle <b>BOOKER</b> Last <b>BOOKER</b>				4. DATE OF DEATH Month <b>MAR</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 24, 1894</b>	9. AGE (In years lost birthday) yrs. <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT J. BOOKER</b>				14. MOTHER'S MAIDEN NAME <b>NICKERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>11:00</b> a. m. Month <b>MAR</b> Day <b>2</b> Year <b>1957</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CHESTERTOWN MD</b>	
				20f. (City or town) <b>CHESTERTOWN</b>		(County) (State)	
21. I certify that I attended the deceased from <b>FEB 18, 1957</b> to <b>MAR 2, 1957</b> , that I last saw the deceased alive on <b>MAR 2, 1957</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. J. Keefe, Jr.</b>				DATE SIGNED <b>3-2-57</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR T. KEEFE, JR. MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shadlersville md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				24a. REC'D BY REGISTRAR <b>Mar 7-57</b>		24b. REGISTRAR'S SIGNATURE <b>Clara L. Barnes</b>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF OTHERS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF NEXT OF KIN		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF NEXT OF KIN		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF NEXT OF KIN		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF NEXT OF KIN		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF NEXT OF KIN		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF NEXT OF KIN		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF NEXT OF KIN		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF NEXT OF KIN		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF NEXT OF KIN		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF NEXT OF KIN		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF NEXT OF KIN		102. SIGNATURE OF OTHERS	

BUREAU V. B.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03008 CERTIFICATE OF DEATH

03011

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>				d. STREET ADDRESS <b>P.O.D.</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T</b> Last <b>BRAMBLE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1884</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry hat chery</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWNER Poultry hatchery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Bramble</b>				14. MOTHER'S MAIDEN NAME <b>Mary Woods</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Hospital records &amp; Ethel Bramble (wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonitis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>March 13, 1957</b> to <b>March 17, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown</b> DATE SIGNED <b>3/17/57</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>ROBERT, W. FARR</b> <b>Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Mar. 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Mar. 19-57</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	



CERTIFICATE OF DEATH

AMERICAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 1

MAR 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03012

## 03009 CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNEDYVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT + QUEEN ANNE'S</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> <sup>First</sup> <u>CLEAVER</u> <sup>Middle</sup>		4. DATE OF DEATH <u>MARCH 13</u> 19 <u>57</u> <sup>Month</sup> <sup>Day</sup> <sup>Year</sup>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> AWIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1878</u> <sup>1878</sup>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Corneilus Davis</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Draper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>William Charles Kennedyville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>arterial hypertension +</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>many</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> p. m. Month <u>19</u> Day <u>13</u> Year <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>57</u> , to <u>3/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>57</u> , and that death occurred at <u>8:24</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		ADDRESS (Street, city or town, state) <u>Chestertown</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>		DATE SIGNED <u>3/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Middletown</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Vellour</u>		ADDRESS <u>Middletown</u>	
24a. REC'D BY REGISTRAR <u>Charles Barnes</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Barnes</u>	
DATE <u>MAR 19 1957</u>			

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 19 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

03019

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03013

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Massey</b> c. LENGTH OF STAY IN 1b <b>6 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural Massey, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3401-4</b> d. STREET ADDRESS <b>1003E Pratt street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>santa</b>		First <b>panzzi</b>		Last <b>panzzi</b>		4. DATE OF DEATH <b>March 24 19 57</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown approx 1908</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Migrant farm worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>218-20-5708</b>		17. INFORMANT <b>papers from his pocket</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Florence M. Joyce</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Florence Joyce, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 25, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>		22b. DATE THEREOF <b>3-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>L. F. and M. S. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR <b>DATE 1 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>Ely. Mulford</b>	

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, address, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

APR 1 1967

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03020

## CERTIFICATE OF DEATH

03014

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>RHODA</b> First <b>DAVIS</b> Last		4. DATE OF DEATH <b>MARCH 6</b> 19 <b>57</b> Month Day Year	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-1877</b> 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH DOWNNEY</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Jos. DAVIS</b> Address <b>ROCK HALL, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> <b>101X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>52</b> to <b>March 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 6</b> , 19 <b>57</b> , and that death occurred at <b>10:20</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>3/8/57</b> ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Mar. 9</b>	<b>Wesley Chapel</b>	<b>Rock Hall Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgard L. Kane</b> ADDRESS <b>Church Hill</b>		24a. REC'D BY REGISTRAR <b>March 9/57</b>	24b. REGISTRAR'S SIGNATURE <b>S. Shurtz</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 13 1957

RECEIVED

03021

## CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res. dence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERVILLE</u>				c. LENGTH OF STAY IN 1b <u>CHESTERVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA NEWHART DUYER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 14 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4, 1868</u>	9. AGE (In years last birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB NEWHART</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. MARY MESSICK, CHESTERVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hardening of the arteries.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12, 1957</u> to <u>March 14, 1957</u> , that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D.				ADDRESS (Street, city or town, state) <u>314.17</u>			
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>				ADDRESS <u>Mullington Md.</u>		24. REC'D BY REGISTRAR <u>MAR 19 1957</u>	
				25. REGISTRAR'S SIGNATURE <u>Ely. Mulford</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and locked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

MAR 19 1957

RECEIVED

03010

## CERTIFICATE OF DEATH

03016

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN life <b>Adult life</b> d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <b>Kent &amp; Queen Anne Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>RFD (Morgnec)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Randolph</b> Middle <b>Garnier</b> Last <b>Garner</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1895</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Usa</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Don't know</b>	
17. INFORMANT <b>Wm. Elias</b>		Address <b>848 Bennett St. Wilm. Dela.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pleural Effusion</b> <b>445X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>X-Ray suggest possible Card Lung Enlarging</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>7 month or longer</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/12</b> , 19 <b>57</b> , to <b>3/21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/21</b> , 19 <b>57</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>3/22/57</b>			
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		M.D. <b>Chestertown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>		<b>Chestertown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Cem. (Big Woods)</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Mar. 23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 22 1957

RECEIVED

03011

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prospect St.</b>		d. STREET ADDRESS <b>Prospect St.</b>	
3. NAME OF DECEASED (Type or print) <b>James H. Johnson</b>		4. DATE OF DEATH <b>March 25, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1890</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kent Co. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hodges</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO. <b>Don't Know</b>	
17. INFORMANT <b>Louis Johnson</b>		Address <b>Prospect St. Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>??</b> <b>??</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-25-</u> , 19 <u>57</u> , to <u>3-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-25-</u> , 19 <u>57</u> , and that death occurred at <u>10:30p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>3-26-57</b> SIGNATURE <b>A.C? Dick</b> M.D. PHYSICIAN'S NAME (Type) <b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 28, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pomona (Col.) Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willie Wells</b>		24a. REC'D BY REGISTRAR <b>Mar. 28-57</b>	24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03012

CERTIFICATE OF DEATH

03018

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
c. LENGTH OF STAY IN TB <b>9 years</b>				d. STREET ADDRESS <b>1 High St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Reuben</b> Middle <b>H</b> Last <b>Kephart</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 14, 1905</b>	
9. AGE (In years last birthday) yrs <b>51</b>		IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>		IF UNDER 24 HRS Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Electrician</b>			
11. BIRTHPLACE (State or foreign country) <b>Clearfield Co. Penna.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George B. Kephart</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Luther</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>I60-I8-2248</b>			
17. INFORMANT <b>Mrs. Harry Haas - Chestertown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis</b> <b>260X</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7 or 8 years</b> DUE TO (c) <b>7 or 8 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Chestertown</b>				20g. (County) <b>Kent</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>March 7, 1957</b> to <b>March 7, 1957</b> , that I last saw the deceased alive on <b>March 7, 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>3/8/57</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b>				M.D. <b>3/8/57</b>			
PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Alexander Cem. Clearfield Co. Penna.</b>		22d. LOCATION (City, town, or county) (State) <b>Clearfield Co. Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Mar. 9-1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Clara L. Barnes</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

RECEIVED  
MAR 11 1957  
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

03013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03019

Form 22d Film G212 3/20/57 312

3-26-57 et

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesestertown</b>		c. LENGTH OF STAY IN 1b <b>19 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Ann's Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Sally</b> Middle <b>Ann</b> Last <b>Malone</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1888</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hosp. records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Operative shock</b> <b>OX</b> DUE TO <b>Arteriosclerotic-diabetic gangrene left leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis-diabetes</b> (c) <b>Arteriosclerosis-diabetes</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mon.</b> <b>2 w. 4 d.</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-14</b> , 19 <b>57</b> , to <b>3-15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-15</b> , 19 <b>57</b> , and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.		ADDRESS (Street, city or town, state) <b>Chesestertown, Maryland</b> DATE SIGNED <b>3-15-57</b>	
PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-19-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMETRY</b>	22d. LOCATION (City, town, or county) <b>Still Pond, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		24a. REC'D BY REGISTRAR <b>3/18/57</b>	
ADDRESS <b>STILL POND, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>E. Howard Jones</b>	

MEDICAL CERTIFICATION

RECEIVED

MAR 20 1957

BUREAU V. B.

STILL BOND, IN  
3-14-57  
ATTORNEY GENERAL

03014

## CERTIFICATE OF DEATH

Reg. Dist. No. *202*

1 PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>WILLIAM HOWARD PENNINGTON</b>				4. DATE OF DEATH <b>March 23 1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1897</b>	9. AGE (In years last birthday) <b>59</b> yrs.	10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>23</b> Hours <b>57</b> Min		11. IF UNDER 24 HRS: Months <b>5</b> Days <b>23</b> Hours <b>57</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Fighter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen Pr. Grn.</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Leonard A. Pennington</b>			
14. MOTHER'S MAIDEN NAME <b>Verma Della Gary</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>-----</b>			
16. SOCIAL SECURITY NO. <b>212-14-3800</b>				17. INFORMANT <b>Mary A. Pennington, Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO (c) <b>Coronary artery disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. st. <b>10:45</b> p. m. <b>3-23</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown, Md.</b>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-15</b> , 19 <b>56</b> to <b>3-23</b> , 19 <b>57</b> that I last saw the deceased alive on <b>3-23</b> , 19 <b>57</b> , and that death occurred at <b>10:45</b> a. M., from the causes and on the date stated above							
ACTUAL SIGNATURE <b>A. C. DICK</b> M.D.				DATE SIGNED <b>3-24-57</b>			
PHYSICIAN'S NAME (Type) <b>A. C. DICK</b>				ADDRESS <b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Fairlee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>				24a. REC'D BY REGISTRAR <b>DATE 3-26-57</b>			
ADDRESS <b>Chestertown, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>			

MEDICAL CERTIFICATION



BUREAU V. S.

MAR 11 1910

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 shall be used as burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

03015

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03021

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>809 High St</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH ELIZABETH RILEY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Lafayette Rowsey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hostetter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Jenny Hickman</u>		Address <u>Chestertown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive heart failure</u> DUE TO (b) <u>Arterial hypertension—</u> DUE TO (c) <u>Arterio-sclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u> <u>many yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <u>attested</u> <u>that deceased from 1-1-54 to 3-23-57 + 3 days undetermined cause on 3-23-57 + death</u> <u>occurred from above causes at 11:55 a.m. 3-23-57</u> ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. CHIEF MEDICAL EXAMINER <u>Chestertown</u> EXAMINER'S NAME (Type) <u>ROBERT W. FARR, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, Q.A. Co. M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward A. Hallow</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 1957</u>	
ADDRESS <u>Mellington Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Barney</u>	

BUREAU V. S.

MAR 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03022

## CERTIFICATE OF DEATH

03022

Reg. Dist. No.

2-0.3

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MACY</u> Middle <u>M</u> Last <u>SCOVIN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs	10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert Joiner</u>				14. MOTHER'S MAIDEN NAME <u>Anna Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Scovin</u>		Address <u>Rock Hall, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>101X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>at least 6 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1956</u> , 19 <u>56</u> to <u>March 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u>		DATE SIGNED <u>3/14/57</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 17</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>				ADDRESS <u>Church Hill Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>3/17/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>James V. Benson</u>			



BUREAU V. S.

MAR 22 1957

150-110

03016

## CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>227 Calvert St.</b>				d. STREET ADDRESS <b>227 Calvert St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>George E. Thomas</b>				4. DATE OF DEATH <b>Mar 26, 1957</b>			
5. SEX <b>male</b>				6. COLOR OR RACE <b>colored</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Sept. 5, 1882</b>			
9. AGE (In years last birthday) <b>74</b> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min			
11. BIRTHPLACE (State or foreign country) <b>Caroline Co. Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Isarel Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Martha Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-20-6266</b>			
17. INFORMANT <b>Mrs Lydia Thomas</b>				18. ADDRESS <b>227 Calvert St. Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>March 26, 1957</b> , to <b>March 26, 1957</b> , that I last saw the deceased alive on <b>March 26, 1957</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Chestertown, MD</b>				DATE SIGNED <b>3/28/57</b>			
ACTUAL SIGNATURE <b>Thomas J. Solon</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>				<b>Chestertown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wallis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 1 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carol Barnes</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the health certificate be secured within 21 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03024

03017

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester Town</u>				c. LENGTH OF STAY IN 1b <u>20 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dyrone Turner</u>				4. DATE OF DEATH Month Day Year <u>3 23 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 5, 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN JONES</u>			
14. MOTHER'S MAIDEN NAME <u>HELEN JONES</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>THELMA JONES 12 MONROE ST. BKLYN, NY.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>57</u> , to <u>3/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thomas J. Solon M.D. 226 Washington Ave</u> <u>Chester town, Maryland.</u>							
ACTUAL SIGNATURE <u>Thomas J. Solon</u>				THOMAS J. SOLON			
19. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>			
24a. REC'D BY REGISTRAR DATE <u>3/27/57</u>				24b. REGISTRAR'S SIGNATURE <u>C. Kennedy Jones</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMTY</u>	
22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>							



WESTING STATE DEPARTMENT OF HEALTH - BUREAU OF  
 CERTIFICATE OF DEATH

STILL BORN

JAN 2 1901 28

WIFE HOME MARKLAND U.S.A.  
 JOHN JONES HELEN JONES

THE JONES IS BORN IN

BUREAU V. S.

MAR 29 1957

RECEIVED

THOMAS J. JONES

BURIAL 3-30-57 MICHIGAN COUNTY

STILL BORN MD

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VEVIA</b> First <b>HENDRICKSON</b> Middle <b>WALTERS</b> Last		4. DATE OF DEATH <b>March 24 1957</b> Month Day Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 30 1876</b>		9. AGE (In years last birthday) <b>80 1/2</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>VICTOR HENDRICKSON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH FORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Miss MARGARET WALTERS, GALENA, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parkinsons disease</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 month postoperative for removal of carcinoma of spleen flexure</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>7 colon</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2-1</b> 1957 to <b>3-24</b> 1957 that I last saw the deceased alive on <b>3-24</b> 1957, and that death occurred at <b>9:34</b> A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert W. Farr</b>		ADDRESS (Street, city or town, state) <b>Chesedown</b>		DATE SIGNED <b>3/24/57</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>		M.D. <b>MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GALENA CEM.</b>	
				22d. LOCATION (City, town, or county) (State) <b>GALENA, KENT Co. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>McMistox Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 28 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ely Mulford</b>	

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 28 1957

RECEIVED